

Safe practice checklist

During the testing and development phases of the various elements of the solutions, it became readily apparent that clinical practice varied significantly across the NHS.

This was particularly evident through a plethora of local shared care guidelines and general inconsistency toward monitoring responsibility. The guidelines are predominantly focused upon transfer of prescribing from secondary care specialist to the primary care GP, and neither the guidelines nor the specialists' discharge letters contain explicit instructions regarding monitoring schedules, responsibility for conducting the monitoring tests and review of results, including action to be taken if results are outside of the norm.

Similarly, guidance on the length of period for supply between blood testing, and communication of changes in dosage directions were also found to be lacking.

Following discussions with the relevant clinical groups and organisations, a checklist for positive practice was proposed to provide a consistent approach.

Safe prescribing practice checklist

- Initiating treatment; information is available to provide to the patient on the risks and benefits of this medicine, confirmation of patient understanding/consent, baseline tests conducted, monitoring need and schedule explained to patient. Patient-held recording document issued and use explained.
- Issues to be addressed within Shared Care Guidelines – clarity of prescribing and monitoring responsibilities. How often will blood tests be conducted and in which location. Which clinician will be responsible for receipt and review of the results, and who will communicate necessary dosage changes to the patient (and to GP if hospital reviewed for GP prescriber). Who will record test results in to the patient-held record document.
- Trusts without Shared Care Guidelines must make similar appropriate arrangements. The British Society for Rheumatology has published guidelines for the monitoring of disease modifying drugs including methotrexate, and which may be a useful source of information.
- All prescribers should avoid the use of 'as directed' in prescribing – a specific dose must be applied to each prescription. Patients often

understand their dose by number of tablets rather than 'mg'; quantity and frequency of dose should be regularly discussed with the patient.

- Repeat prescriptions should be removed from the surgery repeats pile and retained separately for prescriber review prior to authorising by signature. Changes to printer driver software to shade prescription signature space on FP10 / WP10 to alert prescriber to high risk drug might also help in this instance.
- Beware patients attending with other symptoms; signs of methotrexate toxicity or intolerance may present as for example, breathlessness, dry persistent cough, vomiting and diarrhoea.
- Patients receiving methotrexate may be admitted to any ward or receive outpatient treatment for co-existing conditions, and staff in all areas may therefore be involved in continuity of prescribing, monitoring or administering methotrexate as a result. Full medication reviews, conducted by pharmacists, should be undertaken on admission and prescribing, monitoring and administration requirements recorded in the patients notes.
- It is the prescribers responsibility to record the correct dosage and frequency on the hospital drug administration chart, and to strike out the six days of the week when a dose must not be administered in the administration section on the chart.
- Handwritten prescriptions and discharge summary information must be complete and legible and include in full the form, strength, dose and directions.